Pre-crime, 'Prevent', and practices of exceptionalism. Psychotherapy and the new norm in the NHS.

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'Pre-crime', PREVENT and practices of exceptionalism:

Psychotherapy and the new norm in the NHS.

'PREVENT works in what is described as the 'pre-criminal' space. It's about identifying people and behaviour BEFORE it becomes criminal. Nobody is asking you to deal with behaviour in the 'criminal' space. That is for the police. Nobody is asking you to spy or inform. This is about Safeguarding and protecting vulnerable people. It's no more than that'. (NHS England, 2016).

Abstract

Section 26 of the Counter-Terrorism and Security Act 2015 places a duty on local authorities and public sector institutions to have '*due regard to the need to prevent people from being drawn into terrorism'*. Accordingly, NHS staff are now required to attend a Workshop to Raise Awareness of *Prevent* (WRAP), ensuring they are trained to spot the ideological symptoms and psychosocial vulnerabilities thought to predict extremist activity. In this paper, I suggest that the insertion of counter-radicalisation duties into the work of psychotherapists and other mental health professionals is not simply to be understood as an attempt to forestall and avert extremist activity. Rather, drawing on the work of Georgio Agamben and Judith Butler, I argue it can be viewed as an innovative tactic of governmentality whose technologies of surveillance ensure a culture of conformity in the NHS through which a 'state of exception' can be established and normalised. I illuminate this by examining two interrelated aspects of the *Prevent* duty: one, the decision by the government to embed *Prevent* within the existing rhetoric and practice of 'safeguarding vulnerable children and adults'; and two, its discursive representation of the consulting room as '*pre-criminal space'*. I conclude by suggesting that the government's determination to allow '*no ungoverned space in which extremism is allowed to flourish*' (HM Government 2011, p. 9) targets the limits of acceptable speech and so the very conditions for radical thought and critique on which psychotherapy depends.

Introduction.

In 1956, in the immediate aftermath of the McCarthy hearings in the US, the science-fiction writer Philip Dick published a short story called *The Minority Report*. The story portrays a future dystopia where a predictive policing system called the *Pre-crime Division* is dedicated to apprehending and detaining people before they have the opportunity to commit a given crime. It's a terrific story, and many readers will be familiar with Steven Spielberg's (2002) smash hit film of the same name. But it is not only fans of Philip Dick's fiction who will be familiar with the notion of 'pre-crime'. The recent

introduction of the term '*pre-criminal space'* into the lexicon of the NHS constitutes a significant shift in public discourse heralding the government's explicit deployment of healthcare staff in counter-radicalisation duties. Since 2004, the UK government's *Prevent* programme, part of its overall anti-terrorism strategy CONTEST, has outlined the roles and responsibilities of government and public sector organisations in the identification and suppression of radicalisation and extremism. In 2011, following widespread criticism of the programme, the then Coalition government undertook a review of *Prevent* arguing that the previous Labour government had failed to fully acknowledge and tackle the promotion of extremist ideologies deemed responsible for terrorism. In the revised *Prevent* strategy, the NHS was identified as a key partner alongside schools, religious groups and the criminal justice system in the facilitation, detection and reporting of those deemed to hold extremist views and 'pre-criminal' tendencies.

The involvement of the NHS in the *Prevent* strategy was subsequently placed on a statutory footing by the *Counterterrorism and Security Act* 2015 which ensures that every local authority has '*due regard to the need to prevent people from being drawn into terrorism'.* Healthcare workers such as doctors, nurses, psychiatrists, psychologists and psychotherapists now receive a mandatory training programme called Workshop to Raise Awareness of *Prevent* (WRAP) to identify those who are vulnerable to being drawn into both violent and non-violent 'extremism' for referral to the police-led multi-agency intervention programme, CHANNEL. In this context, the definition of 'extremism' is said to be: '*vocal or active opposition to fundamental British values, including democracy, the rule of law, individual liberty and mutual respect and tolerance of different faiths and beliefs*' (*Prevent* Strategy, 2011, p. 107). Those who are identified in the '*pre-criminal space'* as vulnerable to radicalisation may be offered a number of interventions including: anger management; theological support from a Home Office approved intervention provider; family support; cognitive behaviour therapy for attitudes and behaviours; and health, housing and family support.

No crime has yet been committed. Rather, crime is to be prevented. But 'pre-crime' is not crime prevention in the usual sense of the word. Crime prevention is perhaps more usually understood to be something that acts to reduce the opportunities for crime, or something that addresses the context of crime and its social and environmental determinants (Clarke, 1997). By contrast, the *Prevent* strategy is predicated on a notion of 'pre-crime' that focuses on the person and his or her presumed intention to act; on anticipating and forestalling criminal activity that has not yet taken place and indeed may never come to pass. As Zedner (2007) points out in a discussion about the problems faced in the criminological field, '*we are on the cusp of a shift from a post- to a pre-crime*

society, a society in which the possibility of forestalling risks competes with and even takes precedence of responding to wrongs done. In consequence, the post-crime orientation of criminal justice is increasingly overshadowed by the pre-crime logic of security'. (p. 262).

The implementation of *Prevent* within public sector services may be seen as one of the consequences of this paradigm shift from danger to risk, from defence to prevention. Since 9/11, governments worldwide have been under increasing pressure to act pre-emptively and the demand for security ensures that interventions are applied long before there is any possibility of a given crime being committed. It is within this increasingly anxious political climate that that the UK government's *Prevent* programme has come to justify and legitimate the recruitment of NHS healthcare staff to counterterrorism duties, ensuring they are trained to spot the ideological symptoms and psychosocial vulnerabilities deemed to precede and predict extremist activity. But whilst there has been much-publicised criticism of the *Prevent* programme from human rights organisations (Rights Watch UK, 2016) and from those within the teaching profession (National Union of Teachers, 2016) there otherwise appears to be remarkably little discussion of the impact of *Prevent's* surveillance requirements on NHS mental health workers; in particular psychologists, counsellors and psychotherapists whose clinical work crucially depends on establishing and maintaining trust and confidentiality within a secure therapeutic relationship.

Why should this be so? It is true, as Heath-Kelly (2016) has argued, that healthcare staff are currently fully engaged in combating the attempts of successive governments to extend the privatisation of the NHS and may have little time and energy left for thinking about the implications of their new anti-radicalisation duties. However, the alternative thesis I wish to develop in this paper is that *Prevent* has been readily accepted as typical of so-called 'exceptional' security practices that have come to characterise Western society since 9/11 and the subsequent 'War on Terror'. 'Exceptionalism' is a concept that is usually deployed in political theory (Huysmans, 2008; Johns, 2005), international relations (eg. Aradau and van Munster, 2009) and security studies (eg. Burles 2016). It is commonly invoked to designate the vast and arbitrary extension of state powers seen, for instance, in the 'Bush Doctrine's' strategy of pre-emptive strikes, the US Patriot Act (2001) and the enhanced investigatory powers now available to UK intelligence and law enforcement services through the recent Investigatory Powers Act (2016). It includes the instigation of international extra-legal practices such as extraordinary rendition, migration camps and the forced detention of prisoners without trial which have been characterised by some as a '*persistent and comprehensive departure from basic principles of law and human rights, and the formation and establishment of*

new paradigms' (Rostill, 2013) and by others (eg. Aradau and Van Munster, 2009; Bigo and Tsoukala, 2006; Butler, 2004) as the dark underbelly of the modern state, the hidden, violent foundations of sovereign power.

To date, theories of exceptionalism have scarcely been considered within the psychotherapeutic field. But the unprecedented extension to clinicians' duties mandated by the *Prevent* duty I think calls for a willingness to reach out beyond our familiar psychotherapeutic concepts and ideas towards new theoretical frameworks and disciplines in order to examine how this statutory obligation has come to be so successfully introduced into the clinical practice and responsibilities of mental health workers. This act of theoretical or conceptual borrowing is certainly not without pitfalls, not the least because of the risks of attempting to use ideas that are embedded in unfamiliar philosophical and epistemological issues and debates. In drawing on the work of the Italian political philosopher Georgio Agamben then, I am mindful of the need to tread cautiously in territory that extends well beyond my usual academic – and psychoanalytic - comfort zone. However, in common with writers from disciplines as disparate as education (eg. Meskin and Shapiro, 2013), geography (eg Minca, 2007) and nursing (eg Georges, 2008) to name only a few, I find Agamben's writings on sovereign power and 'bare life' to provide a fertile if provocative spur to understanding and re-conceptualising issues and debates within my own professional field; in particular, the complex interweaving of law, governnmentality and security that characterises the *Prevent* programme and its current implementation within UK mental health services.

There are two main sections to this paper. In the first, I outline some of the criticisms that have been levelled at the UK government's implementation of the *Prevent* strategy within public sector services. I then offer a brief introduction to Agamben's theory of exceptionalism and discuss his paradigm of the camp as a 'zone of indistinction' where 'bare life' is produced. I set Agamben's ideas alongside the work of Judith Butler (2004), and argue that the *Prevent* duty may be seen as an innovative tactic of governmentality whose technologies of surveillance ensure a culture of conformity and compliance aimed at establishing and normalising a 'state of exception' within the NHS. In the second section of the paper, I attempt to develop these theoretical ideas by examining firstly how NHS 'safeguarding' has been used as a vehicle for the implementation of the *Prevent* duty; and secondly, how psychotherapists' clinical work is undermined by the government's discursive representation of the consulting room, not as therapeutic space, but rather as '*pre-criminal space'*. I will conclude by suggesting that the *Prevent* strategy targets the limits of

acceptable speech and so the very conditions for radical thought and critique on which psychotherapy depends.

The PREVENT programme: an exceptional practice?

Whilst the UK government has had a long history of counter-terrorism based on its experiences during the 'troubles' in Northern Ireland during the 1960s and '70s, it was not until the Terrorism Act (2000) that legislation acknowledged the expansion of Islamic-inspired terrorism and home-grown radicalisation within the UK and internationally. In the aftermath of 9/11, successive British governments passed a raft of further legislation, including the Anti-Terrorism and Crime Security Act (2001); the Criminal Justice Act (2003); the Prevention of Terrorism Act (2005); the Terrorism Act (2006); the Counter-Terrorism Act (2008); the Justice and Security Act (2013); and the Counter-Terrorism and Security Act (2015) all in an effort to combat the perceived rising tide of international terrorism.

CONTEST, a key component of the UK's National Security Strategy, was initially developed by the Home Office in 2003. Its aim is '*to reduce the risk to the UK and its interests overseas from terrorism, so people can go about their lives freely and with confidence*'. CONTEST accepted the need for intelligence-led assessments not only to advise security planning and operational decisions but also to allow for a more informed understanding of the motivations, aims and techniques of individuals and groups thought to pose a risk of terrorist activity. The strategy comprises four main strands: *Pursue*, which aims to investigate and disrupt terrorist attacks; *Prevent*, aiming to stop people becoming terrorists or supporting terrorism and extremism; *Protect*, which improves security measures; and *Prepare*: which aims to mitigate the impact of any future terrorist attack.

From the outset, it was the *Prevent* strand that met with the most vociferous resistance. Early efforts by the authorities to implement the *Prevent* programme by fostering liaison and dialogue with Muslim groups and communities were met with criticism from the media and right-wing groups who claimed the government was funding radicals (eg. Policy Exchange, 2006). Subsequent criticism following the 2011 revisions of the *Prevent* programme focused on how it was likely to lead to over-reporting of suspect communities (eg CAGE, 2013) as well as significant problems with the evidence base for its 22-factor Vulnerability Assessment used to detect signs of vulnerability to radicalisation (CAGE 2016, Royal College of Psychiatrists, 2016). Whilst Kundani (2012) argues that the *Prevent* programme unfairly targets specific Muslim populations, Coppock and McGovern (2014) critique its

focus on individuals rather than considering the broader socio-economic and political context giving rise to terrorism. Most recently, Baroness Warsi (2017) has argued that *Prevent* fails to acknowledge the impact of the West's failed foreign policies, and ignores the inequality, poverty and gang culture that drive young people towards violent jihad. She goes on to argue that the programme stigmatises young Muslims and stifles public debate.

But following the latest *Prevent Duty Guidance* (2015), published alongside the *Counterterrorism and Security Act* (2015), it is the mandatory implementation of *Prevent* in both schools and higher education that has met with particularly fierce criticism. In 2016, the National Union of Teachers (NUT) voted overwhelmingly against the programme saying that '*it causes suspicion in the classroom and confusion in the staffroom*' (Adams, 2016). In the higher education sector, McGovern (2016) argues that *Prevent*'s identification of the new category of 'non-violent extremism' as central to the process of student radicalisation has little to do with violence or terrorism and more to do with '*a vaguely defined ideological well of illiberalism which, in the view of the Prevent duty guidance, "'can create an atmosphere conducive to terrorism and can popularise views which terrorists can exploit*"' (p. 52). Durodie (2016), too, points to the way the *Prevent* programme reveals *'an implicit willingness to act in bad faith'* (p 6.) on the part of politicians, officials and institutions, claiming that '*coercion through legislation is not the same thing as engagement through inspiration*' (p 6). Other critics, including the Labour MP and barrister Shami Chakrabarti, the Muslim Council and the vice-chancellor of Oxford University Louise Richards, have all voiced concerns about the monitoring and surveillance of university students as well as the vetting of speakers at academic events.

In the light of the above censure from academics, it is all the more surprising that there has been so little attention paid to the *Prevent* programme's implementation within the NHS. However, a trenchant paper by Summerfield (2016) took the General Medical Council, the Medical Royal Colleges, and the British Medical Association to task for failing to speak out, seeing this tacit acceptance of *Prevent* as a '*corrosion of the ethics of the doctor-patient relationship'* aiming *'to prime us for an activity which is a duplicitous deviation from the medical assessment, advice and treatment that has brought the patient to us'* (p 87). Goldberg et al (2016) offer a critique of the rhetoric used by the government, arguing that the term '*pre-criminal space'* has come to act '*as a form of excitable speech',* designed to alert and induce professionals *'to disclose information or make decisions they would otherwise not make in ….comparable circumstances'* (p. 3) More recently, the Royal College of Psychiatrists (2016) has offered strongly-worded position statement, in which they suggest the *Prevent* duty is likely to conflict with the psychiatrist's duty of care towards the patient and may reduce people's willingness to access mental health services.

States of exception and exceptional practices: Agamben and Butler.

To begin to understand the astonishing speed, ease and success with which the *Prevent* programme has been assimilated into the culture, discourse and clinical practice of the NHS, I want to start by suggesting it has already been accepted by both the public and healthcare professionals as but one of '*an array of illiberal policies and practices that are legitimated through claims about necessary exceptions to the norm*' (Neal, 2008, p. 31). It is here that the work of Georgio Agamben, the Italian political philosopher, is particularly rich. Agamben's writing is dauntingly complex, emerging from a deep engagement with thinkers such as Heidegger, Foucault, Arendt and Schmitt in which he analyses and critiques the historical relationships between law, government and sovereignty in modern Western society. His provocative scholarship has sponsored a considerable body of work across multiple disciplines which it is beyond the scope of this paper to review. Here, I will merely attempt to summarise some of the central ideas presented in 'Homo Sacer' (1998) and 'State of Exception' (2005) that will enable me to develop my subsequent inquiry into how the *Prevent* duty has been implemented within the NHS.

Agamben's analysis of sovereignty draws heavily on Foucault's concept of biopolitics and the various ways in which sovereign power not only exercises control over the bodies of subjects, but rather regulates, monitors and manufactures the life and subjectivity of those who fall within the purview of the state. Indeed, following the earlier political theories of Carl Schmitt, Agamben (1998; 2005) defines sovereignty itself in terms of exclusion or exception, arguing that there are events, of which 9/11 is exemplar, where the law and constitutional rights can be breached, diminished or even suspended in pursuit of the state's claim to a necessary extension of its powers during a state of emergency. He subsequently invokes Walter Benjamin's critique of Schmitt's theory of sovereignty which suggests that: '*the tradition of the oppressed teaches us that the 'state of exception' in which we live is the rule'* (Benjamin, 1942/2003, p. 392). Agamben goes on to advance a version of exceptionalism in which emergency powers assumed by the authorities are seen not simply as a temporary, occasional or provisional interruption to the law, but rather come to constitute an ongoing norm for most of Western society.

For Agamben, the logic of exceptionalism acts to override the legal order, blurring the distinction between what is 'normal' and what is the 'exception' and creating what he terms a 'zone of indistinction'. Within this metaphorical space resides 'homo sacer', a figure within ancient Roman

law whose 'bare life' is excluded from the city or polis. 'Homo sacer', the sacred or accursed man, is the individual who can be 'killed but not sacrificed': one who can be killed without incurring penalties because his life has been deemed worthless, yet cannot be sacrificed to the gods because this is an act that only has meaning within the legal framework of the very polis from which he has been banished. In this way, Agamben suggests, 'homo sacer' is reduced to 'bare life' or mere existence, his political and civil rights revoked by the state in order to define, uphold and legitimate the politically qualified lives of others. Deprived of protection from both human and divine law, 'homo sacer' is an outcast maintained in a suspended or liminal state, living neither as a citizen constituted by the conditions of law, nor as someone who is dead and thus excluded from the law's jurisdiction. It is a life deemed to be without value.

It is clear that Agamben's intention here is not simply to evidence the actual existence of 'homo sacer' from an analysis of historical or legal texts. Rather, he introduces this obscure juridical figure in order to illuminate the wider political mechanisms of the exception and the way in which a distinction between 'bare life' and political citizenship itself instates sovereignty by deciding who is or is not permitted to be incorporated within the political body. More controversially he draws on the exemplar of the concentration camp as a paradigm of the kind of space which is neither fully within nor truly outside the legal and social order, but is always both at one and the same time. In this sense, Agamben (1998) views the camp as a space in which the exception is rendered indistinguishable from the norm, a '*hybrid of law and fact'* (p.170) in which any act of violence against the individual passes unpunished. Not surprisingly, his claim that the camp can be considered the pre-eminent biopolitical paradigm of today has been heavily criticised (eg. Ferrari Bravo, 1996; Laclau, 2007; Norris, 2005), but in a careful analysis of the paradigmatic method he elsewhere clarifies the philosophical ground on which this bold idea is based. Just as Foucault uses the Panoptican as a paradigm of disciplinary society, so Agamben (2009) tells us that he uses the camp not simply to index a moral or ethical precedent, but rather as a paradigm for the operation of juridico-political power relations in which the exception becomes established as the norm. In fact, Agamben is extremely careful to deploy the camp as a kind of heuristic or analogy in which the wider logic of exceptionalism and its production of bare life in contexts far beyond the camp may be revealed and problematized. '*The camp'*, he writes '*…is the hidden matrix of politics in which we are still living, and it is this structure of the camp that we must learn to recognize in all its metamorphoses'* (1995, 196-7). Contemporary examples include urban ghettos, detention camps for refugees, detainees and illegal immigrants, hospital beds for those with HIV/AIDS and death row cells for prisoners. In all these cases, he suggests ' *an apparently innocuous space […] actually*

delimits a space in which the normal order is de facto suspended and in which whether or not atrocities are committed depends not on law but on the civility and ethical sense of the police who temporarily act as sovereign' (1998. P.174). Agamben's central thesis is that the conditions of 'bare life' are now becoming the norm, such that '*the state of exception tends increasingly to appear as the dominant paradigm of government in contemporary politics'* (p. 2) and that '*modern totalitarianism can be defined as the establishment, by means of the state of exception, of a legal civil war that allows for the physical elimination not only of political adversaries but of entire categories of citizens who for some reason cannot be integrated into the political system'* (p. 2).

Agamben's (2005) reading of the politics of exceptionalism locates the requirement for it at the limits of the law and liberal democracy, where, as Neal (2008) argues, it could be understood as justified and indeed inevitable. By contrast, Judith Butler (2004) makes no such assumptions. Rather than theorising exceptionalism as some kind of structural necessity requiring and constituted by a sovereign decision, she simply regards its manipulation of law as a strategy of the state, located within the discourse and practices of governmentality. Following Foucault, she defines governmentality as the means by which the state establishes and exercises political power and regulates populations and goods. Through its institutions and technologies, governmentality takes multiple forms, operating via a diffuse set of strategies to surveil, produce and shape the self-regulating subject. In her analysis of the US Government's treatment of the Guantanamo Bay detainees, Butler (2004) points out how the US Government allocated extended powers to itself by suspending the law and transforming '*the operation of power from a set of laws (juridical) to a set of rules (governmental)…..rules that are not binding by virtue of established law or modes of legitimation, but fully discretionary, even arbitrary, wielded by officials who interpret them unilaterally…*' (p. 62). The state's delegation of power to these '*petty sovereigns'* (p. 56) allows it to establish the law as a tactic, '*something of instrumental value and not 'binding' by virtue of its status as law*' (p. 62): in other words, the law '*is not that to which the state is subject….but is now expressly understood as an instrument…one that can be applied and suspended at will. Sovereignty….is, in its current form, a relation to law: exploitative, instrumental disdainful, preemptory, arbitrary*' (p. 83). At the time of writing, perhaps this is most evident in the US presidency of Donald Trump, whose recent series of executive orders proposed in the name of security was supported by new legal doctrines (eg the state secrets privilege, the law of standing, the defence of quasi immunity) that insulated executive conduct from meaningful judicial oversight and review (Rudenstein 2017).

In Butler's reading, then, exceptionalism becomes not a necessity forced upon us by the threat of terrorism, but rather a series of innovative practices continually operating within the discourse and technologies of law, international politics and security. In this vein, it could be argued that the *Prevent* duty has been accepted within the NHS merely as part and parcel of the ever-increasing machine of governance procedures, characteristic of the new public management (NPM) restructuring of health, education and social services that has been taking place in the UK since the 1980s. I have elsewhere (Rizq, 2011, 2012a, b; 2013; 2014) discussed how mental health services operate within an NHS 'market for care' (Hoggett, 2006) that is characterised by intensive monitoring, surveillance and reporting of practitioners' clinical work via widespread mandatory use of performance indicators, clinical outcome measures, league tables and other regulatory benchmarks. The *Prevent* duty slips neatly into these technologies of surveillance, in which an emphasis on compliance with policies, protocols, screenings and assessment tools ensures clinical practice is covered by what McGovern (2016) terms a '*sheen of scientific rationality*' (p. 58).

But picking up the threads of both Agamben and Butler, I want to suggest something further: that the set of practices deployed by *Prevent,* through which it comes to constitute itself as a normal and legitimate part of NHS clinical practice, are also the means by which a new '*zone of indistinction*' has quietly been installed within our healthcare services. In the '*apparently innocuous space*' of the consulting room, where the normal order of clinical work has been suspended by the pre-emptive governance of extremism, I suggest it is possible to discern the '*hidden matrix of politics*' implicit with the *Prevent* duty that constitutes the basis, the very infrastructure of the Agambenian camp. In making this disturbing suggestion it is perhaps important to reiterate that the intention here is not to make hyperbolic ethical comparisons with historical events, but rather to explore the structure, installation and consequences of a particular set of juridico-power relations that have been woven into the NHS with significant implications for psychotherapeutic practice. I want to try to shine a light on this through an analysis of the two central planks of the *Prevent* duty: the decision by the government to designate the would-be terrorist as 'vulnerable to radicalisation' and therefore in need of protection under the existing NHS system of 'safeguarding vulnerable children and adults; and its decision to colonise the therapeutic space with its new discursive construction of '*pre-criminal space*'. It is to both these issues we can now turn.

Safeguarding and the *Prevent* duty.

The framing of young people as 'vulnerable to being drawn into terrorism' was initiated by the then

head of the British Security Service, Jonathan Evans in 2007. At his first public speech, he suggested that terrorists were '*methodically and intentionally…radicalising, indoctrinating and grooming young, vulnerable people'* (MI5, 2007) and that the UK's concern to protect young children from sexual exploitation needed to be extended to cover violent extremism. By 2011, the *Prevent* Strategy was clear that '*Preventing someone from becoming a terrorist or from supporting terrorism is substantially comparable to safeguarding in other areas, including child abuse or domestic violence….',* indicating that '*…the Department of Health has also supported the review of the 'No Secrets' guidance on safeguarding adults. This will embed the principles of Prevent within existing processes for safeguarding vulnerable adults and enable healthcare workers across the country to understand the parallels between Prevent and existing support and intervention processes'* (pp 83-84).

It is certainly novel to view radicalisation as an abusive or 'grooming' process underpinned by risk and vulnerability. Why should this route be chosen? McKendrick and Finch (2017) have discussed what they term the '*conflationary turn'* by which the UK government linked terrorism with the so-called 'Troubled Families' initiative in social work practice. The joining of two disparate issues, they argue, constitutes an ideological leap whereby vulnerable families who come to be viewed through a '*securitised lens'* (p. 11) are deemed to require management via surveillance and security rather than thoughtful consideration of the wider structural narratives of poverty and inequality that might give rise to their difficulties. This is perhaps a useful starting point for thinking about the deliberate location of the *Prevent* duty within the safeguarding agenda of the NHS. For the '*conflationary turn'* which McKendrick and Finch (2017) discuss relies on bringing together two disparate terms, in this case radicalisation and grooming , both of which are now assumed to have something in common. The individual who is being 'ideologically groomed' for radicalisation is assumed to be in some way similar or '*substantially comparable'* to the child who is being groomed for sexual abuse. Each may be said to share certain characteristics, the most important of which is assumed to be 'vulnerability'.

What then counts as 'vulnerable' under the *Prevent* duty? In the case of sexual or physical abuse, there are well-established behavioural and psychological indices that warrant investigation and which may lead to eventual criminal prosecution of the abuser(s). But by what criteria can we judge the individual to be 'vulnerable' to 'ideological abuse'? The ground here is shaky, to say the least. The government's (2012) *Vulnerability Assessment Framework EGR22+*, used as the basis for the *Prevent* training, includes what it argues are 'psychological hooks' that make it more probable that an individual will move towards terrorism. These include factors such as: feelings of grievance and

injustice, a need for identity, meaning and belonging, desire for status, excitement and adventure, the need to dominate and control others, the desire for political or moral change, being at a transitional time of life and relevant mental health issues (Vulnerability Assessment Framework, *Channel,* 2012). Perhaps unsurprisingly, this framework has come under considerable criticism (eg CAGE 2016) not only because the signifiers it identifies could apply to most of the population at some time or another, but also because the academic study on which it is based relies on a highly contestable evidence base and is being widely implemented in a manner far beyond the remit originally intended by its authors.

More importantly, if people are deemed to be 'vulnerable' without there being any agreed basis for that 'deeming', then perhaps, as Butler (2004) suggests '*the license to brand and categorize and detain on the basis of suspicion alone, expressed in this operation of 'deeming' is potentially enormous'*. (p. 76). At present, the interventions prescribed by *Channel* following a referral from *Prevent* are voluntary. However, if anyone refuses to engage with the *Channel* intervention programme, they may be subject to monitoring and surveillance by the police and security services. They may also have their passport seized if the police believe they will travel overseas. More disquietingly, if parents refuse to give consent for children under 18 to engage with Channel, the case can be referred to social services if professionals believe there is a risk of 'significant harm'.

Can we here start to disentangle the blurring of discursive boundaries that heralds the Agambenian 'zone of indistinction'? For despite the government rhetoric claiming the '*substantial comparability*' of its terms, the child or adult who is vulnerable to sexual or physical abuse, who is at risk of significant harm, is *not at all* the same as the individual who is considered to be '*vulnerable to radicalisation*' (NHS England,2017). It is *Prevent's* use of the term 'vulnerable' that fosters confusion in our minds. For in the usual cases of safeguarding and child protection where 'significant harm' is thought to be likely, the individual concerned is not also assumed to be a potential threat to the public. The '*at* risk' individual will be clearly demarcated *by virtue of their physical or emotional vulnerability* from the individual '*as* risk' (Hughes, 2011). For that reason, the 'at risk' individual is never configured as threat to the public. In the 'zone of indistinction' that is constituted under *Prevent* however, vulnerability is configured so as to conceal or blur this demarcation, thereby conflating the 'at risk' with the 'risky' individual. '*Vulnerability',* suggests the *Prevent* Review (2011)*, 'describes the condition of being capable of being injured….; open to moral or ideological attack. Within Prevent, the word describes factors and characteristics associated with being susceptible to radicalisation' (p108)*. Constructing the would-be terrorist as '*substantially comparable'* to the

vulnerable child or adult therefore requires a discursive manoeuvre that revises the meaning of 'vulnerability' away from its familiar psychological connotations of dependence and helplessness and steers it towards the prospect of future radical threat. In this way, the would-be terrorist is presented as an utterly ambiguous figure: at once the vulnerable victim of ideological grooming who is in need of safeguarding, care and support as well as the securitised, hated public enemy in need of incarceration. The individual is understood, not simply as the dependent, emotionally vulnerable patient in need of containment, holding and psychological or psychotherapeutic care, but rather as an already-securitised problem to be managed via monitoring and surveillance, alongside risk management and interventions aimed at averting imagined future catastrophes.

It is precisely here, in the blurring of the 'at risk' and 'risky' individual, we can see the diminished and devalued figure of 'homo sacer' emerging: in this instance, someone whose extremist views are deemed to be a sign of vulnerability, perhaps even of mental illness, and who is therefore believed to be 'at risk' and likely to be in need of 'safeguarding'. In this audacious bureaucratic turn, we find ourselves thrown into the complex territory of mental capacity, something an individual needs to demonstrate in order to be included in the biopolitical order and thus to be considered a legal subject at all. Indeed, the judgement that an individual lacks mental capacity serves to suspend 'normal' law, inaugurating a 'state of exception' in which normal legal rights are substantially diminished (Mental Capacity Act 2005). Where mental capacity is at stake, the individual can be subject to compulsory mental treatment and is perhaps but a short step away from being removed from society altogether.

Within this more ominous Foucauldian narrative, the contemporary social construction of the terrorist, now prefigured as vulnerable child or adult, may be seen as emblematic of the long-standing, symbiotic relationship between security and healthcare (Howell, 2014) in which the 'psy' disciplines have historically been implicated in the construction of the vulnerable and mentally ill as dangerous to society. Indeed, anticipating Agamben's 'zone of indistinction', Foucault (1964) points to the 'wastelands' allocated to the insane in the Middle Ages, where they were confined to institutions in order to control public spaces and clean the streets of problem people. Foucault's madman, like Agamben's *homo sacer*, was constructed as a monster or beast, justifying the dehumanisation of the mentally ill and legitimating their segregation from society. Today, too, as Weller (2017) claims, '*mental capacity dictates the contours of 'states of exception'*, (p. 404); and it is in the subtle discursive blurring of terms contained in the phrase '*vulnerability to radicalisation'* that

we now see the reckoning of who is to be included or excluded - or rather, who is to be included by being excluded - from the biopolitical order.

Perhaps safeguarding is merely a convenient and familiar institutional vehicle through which the 'psy' disciplines can now be persuaded to be party to this reckoning: to act as '*petty sovereigns*' diffusing the power of decision-making about who is and who is not 'homo sacer' via monitoring and reporting the intimate thoughts, beliefs, ideas and fantasies of patients in line with the precepts laid out in the *Prevent* duty. But safeguarding is also an institutional practice through which NHS health workers' compliance can most readily be expected. The glare of publicity surrounding high profile sexual abuse cases such as the Dame Janet Smith Review (2016) into Jimmy Savile and the repeated systemic failures of child protection in the cases of Baby 'P', Poppy Widdison and Victoria Climbie amongst many others are powerful public narratives endorsing the need for support for vulnerable children alongside punitive sanctions for health professionals who fail in their safeguarding duty. The notion of the child's biological immaturity and right to protection under The Children Act (1989) is almost universally accepted within medical, social and welfare services. It is this that provides legitimacy to the child protection and safeguarding practices that are already in place and to which all health practitioners are subject. The conflating of vulnerability with the radicalisation discourse thus recruits an exceptionally powerful and socially-endorsed legislative framework in which the validity of almost any extension to state surveillance practices under the *Prevent* duty is difficult to critique. Indeed, the presumption of acting 'in the best interests of the child' implies a level of benevolent intent that is difficult if not impossible to question.

I suggest that *Prevent's* use of 'safeguarding' to include the notion of 'vulnerability to radicalisation' may thus be regarded as an 'innovatory tactic' of governmentality; one that not only expands the remit of state powers whilst simultaneously diluting the reach of existing legislation that is already there to protect adults and children from abuse, but which also recruits the language and practices of safeguarding as a step towards pathologising (and depoliticizing) certain individuals and groups. Despite a position statement by the Royal College of Psychiatrists (2016) declaring that '*radicalisation is not a mental illness'*, (p. 4) the recruitment of the 'psy disciplines' to counter-radicalisation duties blurs the line between mental health and terrorism in a way that sponsors the belief that 'vulnerability to radicalisation' is a psychological rather than a political issue. In this way, it can be decoupled from the socio-political context within which radical beliefs and ideas may be likely to arise.

Moreover, viewed through the lens of exceptionalism, it is clear that the entire process is undergoing a process of normalisation, in which the necessity for surveillance has been embedded within safeguarding practices that preclude reverting to any prior norm: '*Situating Prevent within safeguarding'* says the government '*will ensure it continues regardless of future changes to NHS organisational structures. It is also in line with wider attempts to mainstream Prevent in other sectors*.' (Prevent Strategy, 2011, p. 84). And so we can see that there will be no return to a pre-existing state of affairs. This is no temporary interruption to the 'normal' business of clinical practice, but rather clinical work itself has been reconfigured to permanently install counter-terrorism duties within its 'normal' practice. As Butler (2004) notes, '*the state of emergency is not limited in time or space…it…enters onto an indefinite future….the problem of terrorism is no longer a historically or geographically limited problem: it is limitless and without end, and this means the state of emergency is potentially limitless and without end'* (pp.64-65).

The consulting room as 'pre-criminal space': psychotherapy and psychoanalysis.

The successful insertion of counter-terrorism duties into pre-existing models of safeguarding and child protection within mental health practice relies on a further premise: the notion of the '*pre-criminal space'*. '*Prevent focuses on all forms of terrorism and operates in a pre-criminal space'* (p. 5), claims the Prevent Training and Competencies Framework (2015), going on to argue that '…..*the health sector contribution operates in the pre-criminal space'* (p. 8). As psychotherapists, we might want to tread particularly carefully in such new territory, for the government's adoption of this highly evocative phrase has an exceptionally powerful discursive impact, one that again relies on a conflation of terms. It is a phrase that not only collapses the extremely important difference between blind justice operating in sphere independent of politics and a national security system directly managed and controlled by political vested interests; it is a phrase that paradoxically conveys the sense of a space where crime has not actually been committed, whilst at the same time evoking the probability of a criminal act occurring at some unspecified point in the future. The term '*pre-crime'* thus invokes the name of the law whilst simultaneously undermining it by claiming an alternative official legitimacy.

Following Agamben (2005) then, this '*pre-criminal space' 'is neither internal nor external to the juridical order and the problem of defining it concerns precisely a threshold, or a zone of indifference, where inside and outside do not exclude each other but rather blur with one another*' (p.23). Just as we have previously seen the blurring of the 'at risk' with the 'risky' individual, so here too we can

detect the conflating of the legal with the quasi-legal as the word 'crime' is co-opted, its meanings, legal associations and anxiety-provoking potential colonising the therapeutic space in the service of an increasingly intrusive and self-legitimating governmentality. Indeed, it is clear that the reporting of those thought to be 'vulnerable to radicalisation' is not on the basis of any legally or scientifically agreed standards of evidence or proof. It is rather, to repeat Agamben (1998), on the basis of a '*hybrid of law and fact'* (p.170), where psychotherapists and other mental health professionals are required to report any suspicious changes to dress and behaviour according to '*rules that are ……fully discretionary, even arbitrary, wielded by officials who interpret them unilaterally…*' (Butler, 2004, p. 62).

I want to suggest that the colonisation of therapeutic space by the '*pre-criminal space*' is established and sustained through *Prevent's* appropriation of something which, in psychoanalytic practice at least, is deemed essential to clinical work. I am not referring to traditional notions of the frame, boundaries and confidentiality here, important as these are to clinical practice. I think this concerns the *ontological status* of the therapeutic space, precisely the kind of status that Agamben (1998) calls into question in his analysis of the camp where, ominously, '*everything is possible'* (p. 97). For psychotherapy too can be thought of as occurring within a 'zone of indistinction': one in which not only is everything – in fantasy – possible, but one in which the principal characteristic is that of *play*. '*Psychotherapy'*, declares Winnicott (1971) '*takes place in the overlap of two areas of playing, that of the patient and that of the therapist. Psychotherapy has to do with two people playing together*' (p. 44). Playing, suggests Winnicott, constitutes an intermediate or 'potential' area of experiencing, in which the child has maximum freedom to explore both the inner world of illusion and fantasy and the outer world of shared reality and is permitted time and space to sort out the difference. Similarly, in the 'transitional' area of experiencing afforded by the transference, patient and psychotherapist 'play' or speak together in a way that eventually allows the dependent patient to distinguish between me and 'not me' and so, through experiences of 'optimal disillusionment', to abrogate omnipotence and find his or her way into autonomy. Psychotherapy thus relies on, is constituted by, the analyst's capacity to maintain an optimum state of play; a state that is inherently precarious, vulnerable to intrusion and liable to collapse. Indeed, '*[t]he precariousness of play*', Winnicott (1971) points out, '*belongs to the fact that is always on the theoretical line between the subjective and that which is objectively perceived'* (p. 59).

Under *Prevent* however, the benign 'zone of indistinction' within the therapeutic space becomes occupied by the *'pre-criminal space'*. The latter is, of course, very different from the safe,

boundaried, potential space of a psychotherapeutic session within which subjectivity may be contained and developed. We might say the '*pre-criminal space'* is one without boundaries, for the space in which a crime has 'not yet' happened is certainly very large indeed, perhaps even infinite. '*Pre-criminal space'* is thus anywhere and everywhere; it applies any time to anyone. Unlimited by the co-ordinates of time, space and location, unhindered by the law under whose name it is authorised, the '*pre-criminal space'* is free to expand exponentially. It is an incursion of state power into the consulting room which, as Butler (2001) repeats, *'structures the future indefinitely'* (p. 65), usurping the neutrality of the transferential space in favour of one coloured by prospective guilt. Within this compromised space, play collapses. The government's determination to permit '*no ungoverned spaces where extremism can flourish'* (HM Government, 2011, p.9) ensures that imagined catastrophic scenarios in the future overtake the possibility of thoughtful reverie in the present: the logic of exceptionalism, emphasising the imminence, threat and likelihood of a future terrorist attack, maintains a space of surveillance and suspicion in which the analyst's role becomes one of patrolling rather than permitting the free circulation of speech, ideas and imagination. Here, the emotional vulnerability of the patient is securitised into the 'vulnerability to radicalisation' of the pre-terrorist, liable to future acts of violence.

And so one of the more serious consequences of this egregious appropriation of therapeutic space is that the 'play' of fantasy and illusion, so necessary for the development of transference, becomes here conflated with *fact*. The policy decision to tie radicalisation to the dissemination of extremist ideologies (Kundnani, 2014) not only engenders the erroneous assumption that what people say they believe ineluctably leads them to act in predictable ways (psychotherapists are here cast as fortune tellers, perhaps); it also presupposes that people know what they mean and mean what they say. Psychoanalysis however, is predicated on the understanding that, within the therapeutic space, people very often do *not* know what they, let alone other people mean; and that people tend to mean very much more than their words actually say. If, as Lacan suggests, language 'speaks us' then it reveals unconscious divisions, contradictions and ambiguities unimaginable to the self-determining and self-monitoring subject presumed by neoliberal rationality.

Within the epistemology of the *Prevent* duty, however, words are treated merely as information that can be reported rather than as complex signifiers with multiple associations and meanings specific to the individual and the therapist with whom he or she is working. For that reason, the public reporting of what is said between patient and therapist cannot convey the private or intimate meaning of a psychotherapeutic session, as Bion (1970) recognised when he claimed that '*the belief*

that an event belongs to a category of 'events of external reality' leads to confusion and contradiction.' (p. 50). Perhaps the reporting of what we might call 'bare words' is constitutive of the '*new algorithmic calculative paradigms'* (Heath-Kelly, 2016, p. 14) within the NHS that now prioritise the population-body as a public asset productive of 'information flow'. In this sense, stripping words of their unconscious significance and meaning constitutes the individual not as someone bearing a unique identity and subjectivity that can be revealed and developed though psychotherapy, but rather as the desubjectified bearer of implicit data from which future terrorist acts will be inferred.

It is the desubjectification of individuals as precursor to the installation of totalitarian regimes that is of course Agamben's main target. As psychotherapists, we too must be alert to such possibilities, for psychotherapy is above all in the business of asserting and sustaining subjectivity. In the case of psychoanalysis, this is a subjectivity that is excessive, polyphonic, double; one whose emergence depends not only on the privacy of a surveillance-free therapeutic zone, but also on the central assumption, established and sustained by the analytic frame, that words are *not* deeds. However embarrassing, horrific, dangerous or unacceptable they are felt to be by patients, words are not deemed to be concrete acts that can literally destroy the self or other people. In the '*pre-criminal space'* however, words and deeds are conflated as the dead hand of literalism moves in to immobilise words within a concrete meaning. In the surveilled consulting room, then, words lose their many-sidedness. They become '*clichéd and criminalised'* as Adam Phillips declares; lexical indices of future extremist activity mandating baleful consequences for the individual outside the consulting room. In such a space, I think it is reasonable to ask whether patients will feel able to speak freely at all, or whether they will feel it necessary to hide their feelings and their fantasies from their therapists - or, even more worryingly, actively display their non-extremist credentials. In this oppressive Orwellian hunt for the radical threat, is it not the patient who is most able to deceive and dissemble who should be considered the greatest risk? And how will we ever know?

Conclusion: '*homo sacer*' in the consulting room.

'*…the essence of the camp'* argues Agamben (1998), '*consists in the materialization of the state of exception and in the subsequent creation of a space in which bare life and the juridical rule enter into a threshold of indistinction, then we must admit* that *we find ourselves virtually in the presence of a camp every time such a structure is created…'* (p. 98).

In this paper, I have argued for a new *'materialization'* of Agamben's 'state of exception': one that has been constructed by the government's *Prevent* strategy in its novel redeployment of the apparatus of 'safeguarding' that securitises mental health practitioners and their patients within a '*pre-criminal space'*. The introduction of mandatory counterterrorism duties into the NHS ensures a culture of monitoring and reporting amongst psychotherapists, psychologists and psychiatrists who are presumed to be best placed to observe and evaluate the intimate thoughts and beliefs of patients deemed 'vulnerable' to ideological abuse. Within this heavily compromised arena, the discourse and practices of *Prevent* sponsor a conflation or blurring of issues in which the *'pre-criminal space'* usurps the therapeutic space, confusing crime with pre-crime, fact with fantasy and words with deeds. Indeed, the whole notion of safeguarding itself becomes confused with security as the 'at risk' vulnerable victim merges into the hated 'risky' enemy in a new instantiation of Agamben's 'homo sacer'.

Against this dark backdrop, it is not only the individual deemed 'vulnerable to radicalisation' or the mentally ill patient who may be cast in this role, subject to mandatory interventions and even segregation in the name of safeguarding. '*Every society*' warns Agamben (1995), *'decides who its sacred men will be*' (p. 139). And so it is clear that the threshold between inclusion and exclusion from the 'polis' is infinitely mobile. Whilst we are all potentially 'petty sovereigns', able to declare others as *homines sacri* – 'Islamists', 'terrorists', 'extremists', 'scroungers', 'shirkers' or even 'scum' according to some popular discourses – we are also liable to be caught up in these spaces of exception ourselves, vulnerable to being reduced to 'bare life'. In any regime of truth we are all at risk. Perhaps for this reason, we urgently need to find a new grammar of critique with which to expose new practices of exceptionalism now opening up within our public sector services.

How are we to go about this? How can we as psychotherapists continue to function thoughtfully in such ethically-compromised spaces? For if, as Foucault (1997) argues, critique is '*the art of not being governed quite so much'* (p. 44), then it is clear from the government's determination to leave '*no ungoverned spaces in which extremism is allowed to flourish*' (2011,p. 9) that the conditions under which such a critique could be developed are precluded by the very practices I have attempted to interrogate in this paper. It is not simply that the *Prevent* duty limits the content of what the patient – and we - might feel free to voice in the consulting room; it is that the ever-diminishing time and space available for thought and reflection within the heavily bureaucratised systems of monitoring and surveillance within the NHS undermine the very ground we need to stand upon in order to properly scrutinise *Prevent* and its policies.

In the current political climate of suspicion, paranoia and moral panic, repeated large-scale acts of terrorist violence produce a 'culture of fear' (Furedi, 2006) sponsoring public outrage and a febrile political and social environment where, as Collins (2004) suggests, *'people draw together; symbols are rallied around; leaders exalted; control becomes more centralized'* (p. 53). In such a climate, it is increasingly difficult yet ever more important to question the actions and motives of the police and governments in their efforts to establish 'security' as the basic principle of state activity. Indeed, I recognise that any challenge to the legitimacy, validity and probity of the *Prevent* duty risks being seen as extremist in itself. Nonetheless, as psychotherapists and mental health practitioners I think we must ask ourselves what kind of psychotherapeutic care is being legitimated under the *Prevent* duty. What kind of psychotherapists can we be when the therapeutic space itself becomes occluded by the '*pre-criminal space'*? What counts as therapy where counterradicalisation discourses pre-empt and colonise the very spaces of free speech and imaginative thinking on which psychotherapy depends? '*The ghost of the camp'*, writes Minca (2005) *'today roams our cities, our classrooms and our consciences'* (p. 411). It surely haunts our consulting rooms too, and we must find ways of unsettling these intrusive practices of exceptionalism that cast an already-securitized shadow over the psychologically distressed and vulnerable in our care.

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